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MORE THAN A PRAYER: PASTORS' PERCEPTION AND PRACTICE OF MENTAL
HEALTH SERVICES

A thesis submitted in partial fulfillment of the requirements for the degree of Master of
Science at Virginia Commonwealth University

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Abstract

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By Jessica Janeé Young, B.A.

A thesis submitted in partial fulfillment of the requirements for the degree of Master of
Science -at Virginia Commonwealth University.

Virginia Commonwealth University, 2010

Major Director: Micah L. McCreary, PhD.

Associate Professor, Department of Psychology

While African Americans show similar rates of mental health concerns, they seek and obtain significantly fewer traditional mental health services (MHS) as compared to other groups. One alternative to traditional forms of MHS is the use of church-based resources, such as pastoral counseling. Pastors frequently report counseling as a large part of their duties. Therefore, their perceptions about mental health have a major impact on services that parishioners receive. This online survey assessed 40 pastors' perceptions about mental health services, as well as perceived needs for information or training. Attitudes about mental health were significantly related to variety of counseling provided and frequency of counseling. Attitudes toward mental health, church size, and pastoral education did not significantly

predict counseling or referral. Topics discussed in counseling and desires for more training were evaluated and areas for future intervention are discussed in light of results from this study.

More than a prayer: Pastors' perception and practice of mental health services

While African Americans show similar rates of mental health issues such as depression and anxiety in comparison to other ethnic groups, research has consistently indicated that they seek and obtain significantly fewer mental health services (MHS; Ammerman, Corbie-Smith, St. George, Washington, Weathers, & Jackson-Christian, 2003; Blank, Mahmood, Fox, & Guterbock, 2002; Corbie-Smith, Thomas, & St. George, 2002; Diala, Mutaner, Walrath, Nickers, LaVeist, & Leaf, 2000; Gamble, 1997; Mattis, 2007; Neighbors, Musick, & Williams, 1998; Snowden, 1999; Thompson, Bazile, & Akbar, 2004; Young, Griffith, & Williams, 2003) . Possible reasons for this discrepancy stem from a myriad of issues from pervasive medical distrust in the African American community to lack of social resources or appropriate economic means to get mental health care. African Americans also seem to have more negative attitudes about mental health, such as a stigma around mental disorders, and disbelief in the ability of therapists to treat them fairly and help with problems (Diala, et al., 2000; Frazier, Mintz, & Mobley, 2005).

It seems that one alternative to more traditional forms of mental health care, especially in the black community, is the use of mental and social resources in the church. It has long been established that rates of religiosity are extremely high in the African American community. Some researchers have recorded rates as high as 90% (Mattis, Mitchell, Zapata, Grayman, Taylor, Chatters, et al., 2007). Studies have correlated high levels of religiosity with several positive life outcomes, such as higher overall life satisfaction, lower depressive symptoms, and better coping strategies in

dealing with stressful situations (Mattis et al, 2007; Larson, Hohmann, Kessler, & Meador, 1988; McRae, Thompson, & Cooper, 1999). Because African Americans use the church as a place for mental resources, it is important for psychologists and clergy to collaborate on ways to help parishioners with their mental health issues, whether through community-based interventions, training for pastors, or through referral resources. Pastors, as the leaders of churches, have significant influence on their parishioners. They are the people who must sign off on any outside resources being involved with church members. They also frequently report that counseling is a large part of their pastoral duties. As such, their perceptions and attitudes about mental health have a major impact on services (both internal and external) that parishioners receive. While this idea of collaboration is idyllic and potential very useful, there has been a disconnect between the theory of bringing psychologists and clergy together and the action that should follow it.

A few studies have outlined theoretical models for collaboration between clergy and psychologists in order to provide services to parishioners. One group of researchers reported on a successful, community-based collaboration between clergy and psychologists (Benes, Walsh, McMinn, Dominquez, & Aikins, 2000). Benes and colleagues (2000) propose two different models of service delivery that would allow clergy and psychological professionals to collaborate (See Figure 1). In the first type, the direct service model, the clergyperson refers his or her parishioner to a psychologist, who then extends therapy. This would be good for extreme situations or ones the clergyperson feels he or she cannot handle appropriately. The second option is the indirect service delivery model. For most problems, clergy can handle the problems adequately (maybe

even better than psychologists because of their history with members) if they have the right tools. These tools could include things like more sophisticated information about depression, marriage problems, etc. The best collaboration between psychologists and clergy is where both models are possible and at appropriate times.

Figure 1. Benes, et al. (2000).- Service Delivery Model

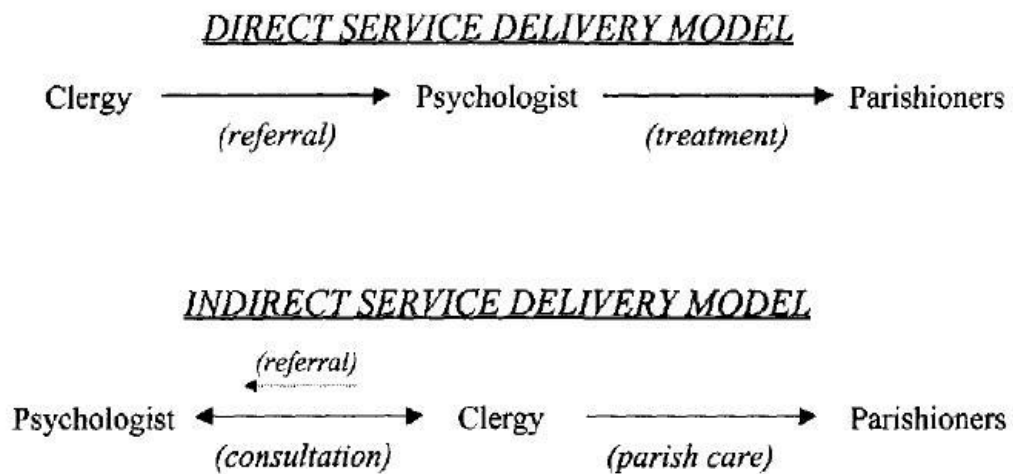


Figure 1. A direct service model assumes that clergy function as the referral source for psychologists and that psychologists provide direct remedial services. An indirect service model assumes a collaborative, consultative relationship between psychologists and clergy that empowers clergy to provide a continuum of services for parishioners.

While this is an excellent model that has been shown to work in a community-based organization, it is incomplete. The processes are clearly outlined, but person-variables are not taken into account. As indicated above, these person variables are part of the reason that people in the black community get fewer mental health services than other ethnic groups. There are many factors that would influence the success of this model in a black religious community, relating to pastors, parishioners, and psychologists. Without

addressing these factors in the model at each level, and taking them into account, the model is unfinished.

At the level of pastors, several factors influence both their counseling practices in the church and their own willingness to engage in dialogue with psychological professionals. One factor has to do with the pastors' attitudes about seeking MHS themselves. A pastor who is unwilling to seek out MHS or has a stigma about mental health will be far less likely to refer his or her parishioners, or to use psychological resources in the church setting. Level of education is also an important variable to consider. Mattis (2007) found that pastors who had more education were more likely to refer their parishioners to MHS than others. For example, pastors who go to seminary generally complete course work on pastoral care in the church, and learn about MHS resources. They are more likely to be able to engage in sound, effective, counseling in their churches as well as know when they need to refer to a psychological professional. Also relevant is the pastors knowledge of and relationship with social service agencies in the area. If pastors don't know that there is a community clinic, or do not feel comfortable with the staff, they may not be willing to refer their members and might prefer to try to handle the issue on their own. This is also especially important for indirect service delivery. There are many problems that could be handled by the pastor within the safety of the church community if he or she has the appropriate training. Another crucial concern is pastors' relationships with their parishioners. They must have built a relationship of trust to the point that members will follow their advice if referred.

At the level of the parishioner, similar to the pastor, first and foremost is the perception of MHS. As previously noted, there is a high instance of stigma toward both medical and psychological professionals. Since the pastor has been used as a safe method for receiving counseling, a pastor mentioning referral or use of a social resource agency could provoke a negative reaction from a parishioner with high feelings of stigma. This is another reason indirect service delivery is such an important piece of the equation. Some parishioners may only be willing to take advice or help from ministers. However, some parishioners may not feel comfortable talking about certain issues with their pastors. Young and colleagues (2003) asked churchgoers the types of things they felt they could talk to their pastors about. Most felt comfortable talking to pastoral leaders about some things, but reported apprehension about talking to pastors about sex, drugs, domestic violence, and other more sensitive issues. In this case, the direct service delivery model might be more appropriate. Another crucial factor to consider is whether these parishioners have access to insurance if referred, or if there are social resources available. There may be a situation where the pastor is truly the only option for receiving MHS, especially in rural and/or impoverished communities.

At the level of the psychologist, both pastors and churchgoers reported that it was important that the professional have at least some knowledge of religion and was willing to include it in therapy (McMinn, et al., 1998; Moore, Kloos, & Rasmussed, 2001). This does not mean that the psychologist needs to be the same denomination as the pastor or the parishioner, but that he or she is willing to talk about religion as a part of the therapeutic plan and process. Also important, is the psychologist's relationships with area

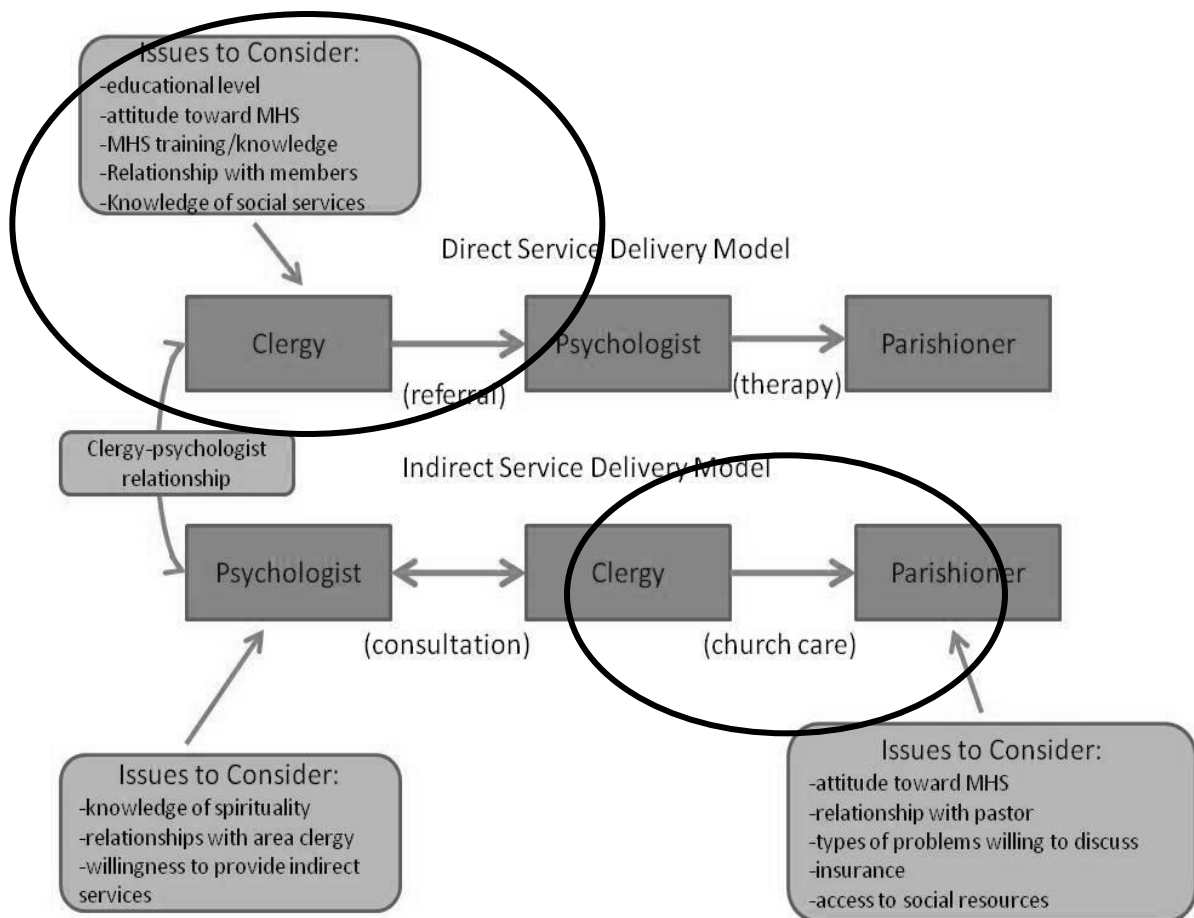
clergy and religious organizations. A psychologist can help neither the pastor nor his or her parishioners if they have not first developed a reciprocal sharing relationship with the pastor. In reality, this is the first step in the clergy-psychologist collaboration, which happens before either indirect or direct services are delivered. Secondly, psychologists must be willing to expand their conceptions of service delivery. Some professionals may only want to deliver one-on-one therapy with clients. But in order to operate well within this model, they must be willing to both counsel parishioners and offer pastors the necessary training to provide MHS in their own churches.

When these various person-factors are considered, a simple model becomes considerably more complex, but probably no less effective. The key is that each of the questions previously raised about parishioners, pastors, and psychologists is addressed in the model. Understanding the needs of all parties involved will help to make this service delivery model applicable to the larger community, and to provide assistance to pastors in caring for the mental health needs of their parishioners.

The adapted version of this model is one that addresses the many variables that influence how pastors, parishioners, and psychologists interact surrounding MHS (see Figure 2). Note that while there are also several factors that influence parishioners' involvement with either pastors or psychologists in MHS, this study focuses on pastors perceptions and actions. This model acknowledges that before any of this service delivery can begin, there must first be a working relationship between clergy and psychologists based on trust and respect. Through church-based interventions as well as surveys of

pastors and psychologists, it has been established that pastors are more willing to seek the help of psychologists if they feel that a mutually beneficial relationship has been formed where neither the psychologist nor the clergy person is the sole expert (Ammerman, Corbie-Smith, St. George, & Washington, 2003; Reed, Foley, Hatch, & Mutran, 2003; Milstein, et al., 2008). This sense of reciprocity is essential to the creation of a true collaboration, which can then lead to the provision of both direct and indirect services to parishioners.

Figure 2. Adapted Service Delivery Model



Therefore, it is important to investigate how pastors feel about MHS in general. This inevitably affects their counseling and referral practices, but we need information about the magnitude of this relationship. Therefore, this study addresses both a) the variables that could influence the forging of a relationship between the clergyperson and the mental health community and b) the nature of the clergy care and referral that happen within the context of the church.

Study Purpose

The purpose of this study is to assess pastoral perceptions and attitudes about mental health services inside and outside the church, as well as to assess perceived needs for information or training for pastors to better their ability to care for members.

Understanding this first level, the “gateway to MHS” for African-American churchgoers, (Milstein, et al., 2008) can help to strengthen the services and resources psychologists are able to provide to pastors and their parishioners.

Literature Review

Low Service Seeking Among African Americans

Mistrust. Although African Americans show similar prevalence of major depression than whites, they are significantly less likely to have sought any kind of mental health services (Ayalon & Young, 2005; Snowden, 1999). This mistrust began particularly with the medical community, with which psychologists and therapists have become synonymous, and dates back to the infamous Tuskegee study which denied treatment for syphilis to hundreds of African American men in order to complete a research study

(Diala, et al, 2000; Gamble, 1997). This injustice has led many African Americans to be leery of going outside their own communities for medical or psychological care.

However, this mistrust might also be related to sharing intimate personal problems with anyone of a different race. There is the concern that someone who is not African American (whites in particular) will not be able to understand some of the struggles of African American life (Thompson, Bazile, & Akbar, 2004). In fact, Nickerson, Helms, and Terrell (1994) found that cultural mistrust of Whites was an even stronger predictor than opinions about mental health for whether or not African American students would seek services at a clinic where they were likely to receive a white therapist. This suggests that cultural mistrust is likely to keep African American from even initiating the process of seeking services for mental health issues.

Even for those African Americans who do make the decision to seek therapy, studies have indicated that having a therapist of a different race has been negatively associated with various treatment outcomes. Sanders Thompson and Alexander (2006) found that having a white therapist was negatively associated with understanding treatment goals and strategies used in therapy. They suggest that perceptions of race as a social category may have limited open communication and interactions between the client and the therapist. Wade and Bernstein (1991) found that when counselor and client race was matched, African American females attended more therapy sessions. In addition, those counselors who had been trained in cultural sensitivity were rated by clients as being more credible, and were rated higher by clients on unconditional regard and empathy.

Stigma. In addition, there are a host of negative attitudes specifically surrounding psychological care and mental health (Diala, et al, 2000; Snowden, 1999; Thompson, Bazile, & Akbar, 2004). For instance, the Black community has long prided itself on the strength of family ties and the ability of the family unit to “make it through anything.” For some, seeking professional help would signal weakness and a loss of pride. Families are supposed to handle problems internally, not go to outsiders for assistance. If seeking outside help is acceptable, it is only for very serious problems. There is a pervasive stigma about mental disorders in general, for fear of being labeled “crazy” or going to a “shrink.” Thompson and colleagues (2004) found that only 9% of African Americans in the National Survey of Black Americans in 1994 had ever used mental health services. Poorer people and those who reported higher stigma about mental health issues were more likely to see ministers instead of professional psychologists. The study also found that among African Americans who had sought mental health services, many had bad experiences which led to early termination, whether or not symptoms had subsided. (Thompson et al., 2004). Though the authors don’t mention it, the news of these negative experiences could easily spread by word of mouth, reinforcing others’ negative attitudes about mental health care. Not surprisingly, they found that attitudes about mental health significantly predicted whether or not people had sought out mental health services. Thompson, Bazile, and Akbar (2004) found that some African Americans reported that seeking mental health services was only necessary for “serious” problems such as schizophrenia or suicidal thoughts. They also found that they were more comfortable with the term “counseling,” which seemed less severe than “psychotherapy.” Negative

reactions to therapy may be especially jarring for African American men, who indicate difficulty building rapport with therapists and not wanting to go to therapy until the situation becomes unbearable (Duncan, 2003). If African Americans do go to therapy, it is also important that the therapist is able to talk about race as a part of the therapeutic relationship (Cardemil & Battle, 2003).

Economic resources. Another important factor in the disproportionate use of mental health services by African Americans has to do with lack of economic resources (Diala et al., 2000; Snowden, 1999; Thompson et al., 2004). African Americans are more likely to report economic hardship than majority ethnic groups (Corbie-Smith, Thomas, & St. George, 2002). This means that they are less likely to have health insurance, which might pay for counseling. In fact, they are less likely than other ethnic groups to even have a primary care provider, much less insurance that provides for mental health care. Another issue is that African Americans typically have larger families but lower relative household incomes. This situation provides for fewer expendable resources that might pay for mental health services. In addition, African Americans may live in communities that have fewer social resources such as mental health centers or community clinics. Even when those resources are available, one study found that African Americans reported limited knowledge of which resources were available to them (Thompson et al., 2004).

Use of the Church as Mental Health Services

High religious involvement. African Americans have extremely high rates of involvement in religious activities, with some studies reporting as many as 90% of African Americans who ascribe to religious beliefs. For example, Ayalon and Young

(2005) found that African American college students were more likely than their White counterparts to indicate that spirituality played a significant role in their lives. They were more likely to use religious services as a source of help for mental and emotional problems and less likely to use traditional MHS as a source for these problems. Studies have indicated that religiosity is related to sense of overall well-being and psychological health (Frazier, Mintz, & Mobley, 2005). As such, it seems that the church provides an alternative form of mental health services. As mentioned earlier, African Americans also have higher rates of early termination because of displeasure with therapy (Diala, et al., 2000). Another possible reason for this could be a lack of discussion of religion, which is important to most in this ethnic group. Despite the difficulty researchers have had in nailing down a definition of “religion”, many have acknowledged that it is important to include in a therapeutic conceptualization (Moore, Kloos, & Rasmussen, 2001). For people who ascribe to religious beliefs, religion is often an integral coping strategy and is frequently an important part of the meaning making process. For example, Thompson and colleagues (2004) found that especially older African Americans used prayer and church activities as a way to cope with mental health issues.

Importance of religion as a therapeutic concern. Unfortunately, one study of clients in therapy found that many religious persons were concerned that their therapists ignored their religious issues (Larson, Holmann, Kessler, & Meador, 1988). In fact, several studies also found that psychologists frequently reported little or no specialized training in dealing with religious issues (Adkinson-Bradley, Johnson, Sanders, Duncan, & Holcomb-McCoy, 2005; Benes, Walsh, McMinn, Dominguez, & Aikins, 2000;

McMinn, Chaddock, Edwards, Lim, & Campbell, 1998; Moore et al., 2001). If their religious beliefs are not included in the therapeutic situation, this could lead to early termination or even failure to seek mental health services (MHS) in the first place.

Weaver, Flannelly, Flannelly, and Oppenheimer (2003) reviewed studies on psychology and religion over a 20 year period. They found only 44 studies that combined the two disciplines in that time period. Across these studies, they found that 40% of religious persons had sought MHS from the church.

Some have even argued that religious blacks have more highly developed coping skills because of their religiosity and that the church may even act as a therapeutic group for them (McRae, Thompson, & Cooper, 1999). Participation and involvement in religious services and the church community can provide emotional and social support (Kloos, Horneffer, & Moore, 1995; Blank, Mahmood, Fox, & Guterbock, 2002). They provide a ready-made community with which people can share good and bad news, as well as being a consistent source of social interaction and acting as a window to the community. Clergy play an important role as spiritual leaders of these important communities. In fact, several studies have indicated that at least 30-40% of churchgoers go to the church as their first source of emotional and psychological help (McMinn et al., 1998; Weaver et al., 2003).

Church based interventions. Seeing the integral contribution of the church to the mental and physical health of African Americans, a number of researchers have implemented behavioral and health interventions in the context of the church. Though in theory this collaboration may seem like a simple process, previous research has indicated

that collaboration between churches and psychologists can be very difficult. This is especially true for African American churches, which have very tight knit communities. Reed, Foley, Hatch, & Mutran (2003) conducted a health intervention for older African American church members called the Durham Elders Project. They found that the first step was to make contact with pastors, who then recommended church members who were actually trained to run the intervention. They found that church members were more likely to become involved when they recognized those who were giving the intervention. Also, they found that pastors who pushed the intervention had more members to participate fully. They found that some of the mistrust they faced when first approaching churches was alleviated by building a continual and mutual relationship with them. Therefore, going in to do the interventions for a second and third year was much easier than the first. Similarly, Ammerman, Corbie-Smith, St. George, and Washington (2003) found that getting church parishioners involved was the key to getting the intervention off the ground. They also involved them in the research aspect of the process, having them look at the qualitative data from surveys and focus groups and offer their suggestions. They reported that church members and pastors alike were adamant about being called “participants” and not “subjects”—this was related to them feeling like equal partners rather than guinea pigs for the researchers.

As mentioned in great detail above, Benes, et al. (2000) created a model for service delivery that is the theoretical underpinning for this study. Milstein, Manierre, Susman, and Bruce (2008) developed a different project in which they worked directly with clergy rather than working with parishioners themselves. In this model called the COPE model

(Clergy Outreach and Professional Engagement), clergy and psychologists share information about parishioners/clients. They use a system of religion-inclusive burden reduction through sharing of resources. For instance, a clergyperson would speak to a therapist about one of his or her parishioners who is seeking therapy, sharing behavioral observations, helping develop a more detailed family history and reassuring parishioners in their attempts to trust the therapist. In turn, psychologists can use their knowledge about church activities to provide clients with possible venues to seek social support or other structured activities. This model also includes a process by which clergy and psychologists present forums on various topics to help enlighten the professionals from the other discipline. For instance, psychologists might give a symposium on depression while ministers give a talk on the purposes of bible study or Sunday school activities. This type of intervention seems to adequately address some of the issues raised in previous research examining clergy counseling practices.

Counseling Practices of Clergy

Clergy as a gateway. The combination of the minimal amount of attention paid to religion by psychologists and the proximity of clergy to their parishioners makes pastors the principal gateway for mental health services for churchgoers (McMinn et al., 1998; Milstein et al., 2008). As leaders in the African American community, clergy attitudes have significant influence on their parishioners (Richardson, 1989). They are better able to recognize behavioral and emotional changes in members, and can react to them quickly. In fact, Young and colleagues (2003) found that ministers reported actually seeking out members who appeared to be emotionally troubled or exhibited drastic

behavioral changes. In one study, clergy reported that they spent a minimum of 15% of their pastoral time doing counseling with their parishioners. This percentage was even higher in rural areas, where there are fewer social resources and community mental health centers (Blank et al., 2002). However, the extent and nature of the counseling services are dependent upon the perceptions, beliefs, and skills of the clergy themselves. For instance, one survey of ministers indicated that they frequently use scripture and spiritual advice as a part of their counseling sessions. Some reported that they believed emotional problems were caused by unsatisfactory relationship with God, but more reported that these problems were due to life stressors. Clergy who were more educated were more likely to have referred to a psychological professional (Mattis, 2007).

Still, it is important to note parishioners are usually the ones who seek therapy, and they reported that they were uncomfortable talking about some types of problems with clergy (Young et al., 2003). Factors affecting a parishioner's desire to go see clergy included: character of the clergyperson, previous relationship, perceived competence, and shame or uneasiness about issue. They felt comfortable talking about issues with money, bereavement, family or life problems. They also frequently went to clergy to talk about emotional issues or major life decisions. On the other hand, churchgoers reported apprehension about talking to pastors about sex, drugs, domestic violence, and other more sensitive issues.

Clergy expertise and knowledge. Clergy noted that they could use more training with certain types of issues, as well as locating social resources to pass along to their members (Neighbors, Musick, & Williams, 1998). Kloos et al. (1995) found that clergy

said they needed training in psychological issues, and that they sometimes had difficulty deciding when to refer their parishioners to psychological professionals (also see, Mattis, 2007; Neighbors et al., 1998; Young et al., 2003). For these types of issues, churches and clergy need psychologists to act as community advocates, consultants, program evaluators, and other roles. Conversely, clergy can offer a wide range of expertise to psychologists, including specific ways to address personal needs and an enriched understanding of religious issues and how they are lived out in the lives of churchgoers. Clergy and psychologists acknowledge that this kind of collaboration is important: McMinn et al. (1998) reviewed a group that comprised both disciplines, and 80% of those surveyed indicated that it was important to consider religion in therapy. However, very few psychologists reported actually using religion in therapy, and very few clergy reported using psychological resources in their counseling. It seems that there is a recognized need, but few people often act on this need. In their perceptions of what would facilitate collaboration, professionals from both disciplines noted shared beliefs, shared information, and mutual respect as key factors. It is important to note that the concept of “shared beliefs” does not mean denominational or doctrinal agreement, but shared beliefs about the connection between psychological and spiritual issues.

Previous research indicates that clergy level of education, prior pastoral training, size of the church, and other variables impact referral and counseling practices of clergy. For instance, Blasi, Husaini, and Drumwright (1998) found that pastors who were more educated and those who were full-time pastors were more likely to refer their parishioners to specialists (mental health or medical) for help with specific problems

The challenge with all of the articles reviewed which examine clergy behaviors and attitudes is that they are using qualitative interview data, with questions developed independently by each set of researchers. Therefore, there is little reliability across studies, and we are unaware of the exact questions being asked. However, since there is very little research available in the field, the less sophisticated exploratory research is as necessary as it is incomplete. On the other hand, the data examining service seeking behaviors in African Americans is based on large scale census-like data sets using statistical analyses. These data are much more generalizable to the larger population and give a better estimation of the actual rates of service seeking and attitudes toward mental health.

Understanding typical pastoral care. Pastoral care, as described by Wimberly (2006), “facilitate[s] personal agency and efficacy” by allowing people to examine their problems in a holistic manner. Young and Griffith (1989) distinguish between three separate types of pastoral counseling: religious counseling, pastoral mental health, and pastoral psychotherapy. From their descriptions, religious counseling is the type most exercised in the church; it is characterized by a focus on relationships or spiritual-emotional crisis, a therapeutic relationship based on a communion with God, and religious guidance. Typically, rather than the traditional conceptualization of counseling, this definition better describes what happens in church counseling sessions, and in African American churches in particular. Likewise, Mollica, Streets, Boscarino, and Redlich (1986) describe the hallmark of pastoral counseling in the African American church as its full integration of spiritual and religious aspects (quoting scripture, religious

service attendance) into the helping relationship. This is the major difference between pastoral counseling, and a psychotherapy where spirituality is talked about and explored. While spirituality is the forefront of pastoral counseling, it is the background in traditional therapy, even if it is inclusive of religious/spiritual issues.

Psychologists who seek to collaborate with clergy must keep in mind the distinction that should be made between psychotherapy and pastoral care. Pastoral care can be described as “supportive” rather than therapeutic in many cases. For people who may need to simply talk through a specific problem, or are seeking reassurance from a trusted authority, it is perfectly suitable in order to address the symptoms or problem currently being faced. Often, the fact that these supportive conversations can take place in a familiar setting makes them more effective than traditional psychotherapy might be. Wiley (1991) describes the African American church as “a caring community” in which there is an inherent support system against oppression and struggle. She argues that this system should help people work toward spiritual and emotional freedom. This system is holistic in nature and seeks to address mental, emotional, sociological and economic needs. This kind of support provides a wonderful foundation for clergy to begin the process of healing in the church community. However, clergy recognize that there are some problems that cannot be tackled purely within the context of the church. As such, an important function of pastoral care is referral (Richardson, 1989), and this function is what makes clergy attitudes and relationships with mental health professionals so important to investigate.

Statement of the Problem

It has long been established that African Americans demonstrate similar levels of mental illnesses as the majority population, but are much less likely to seek professional mental health services, and much more likely to terminate treatment early if they do go to a counselor (Corbie-Smith et al., Diala et al., 2000; Snowden, 1999; Thompson et al., 2004). A host of factors have been implicated in this disparity. They include stigma about mental health, past negative experiences, strong family units, sense of pride, and lack of economic resources, to name a few. One interesting finding is that African Americans tend to go to religious leaders for counseling rather than psychological professionals. This is not surprising considering the high proportion of African Americans who assert religious affiliations (Frazier et al., 2005; McMinn et al., 1998; Weaver et al., 2003). However, quantitative studies that measured the seeking of psychological or other mental health services on a large scale give us little qualitative information about the nature and quality of those services. On the other hand, qualitative studies that give more detailed information are generally on a smaller scale and therefore are not very generalizable to the larger population.

The other perspective on this issue is that of the clergy. Almost exclusively, qualitative interview studies have been used to assess the counseling and referral practices of clergy, along with their beliefs about mental health issues (Mattis et al., 2007; Neighbors et al., 1998, Young et al., 2003). For every study, a different set of questions and a different format was used, making it difficult to synthesize information across the small body of research. However, most studies found that clergy spent a

significant amount of their time counseling their parishioners about issues from marriage, to bereavement, to money. No study reviewed here used any kind of quantitative measure to assess pastors' attitudes about mental health. Here is a serious gap in the research. Previous studies have indicated that attitudes about mental health significantly predicted service seeking behaviors in religious African Americans. Similarly, it is likely that pastors' attitudes about mental health will significantly predict pastors' counseling behaviors and referral practices. Aside from a few small scale studies, there is still little information about how pastors counsel and whether they feel they have the tools they need to do this effectively.

Using Benes et al.'s (2000) indirect model of service delivery, psychologists can reach churchgoers by ensuring that their pastors have all the necessary information to adequately meet the psychological and mental needs of their congregations. This could include training for pastors such as tactics to deal with depression or interpersonal problems, as well as comprehensive information about mental health services and resources in the immediate area of the church. Psychologists could help clergy discriminate when it is necessary to refer, but then consult with them in the event that the parishioner needs professional psychological care. In this situation, the psychologist is able to incorporate religious issues and events into the treatment plan to provide a more comprehensive, tailored solution.

However, the model as presented by Benes and colleagues (2000) is incomplete because it does not address the factors that influence whether people at each level of the service delivery will interact with each other. For instance, in order for the indirect

service model to be effective, psychologists must first understand the beliefs, practices, and perceived needs of clergy. The next step is to provide those clergy with information, training, and services that will help them to provide adequate mental health care for their parishioners. Pastors and psychologists need to understand parishioners' feelings about mental health services and willingness to address certain issues with either a pastor or a psychologist. The next step is to decide whether it is most appropriate for pastors to deliver MHS within the church community (indirect service model) or for pastors to refer their parishioners to psychologists (direct service model). Before these "next steps" can be reached, the person-variables at each level of the model must be explored.

This study is an exploratory investigation which aims to discover the attitudes, counseling practices, and perceived needs of African American pastors, the first level of the service delivery model. Using both qualitative and quantitative methods, current practices and future goals of these clergy were assessed. Pastors completed a survey which investigated their attitudes toward mental health service seeking. In addition, they answered qualitative questions which asked about their previous training, counseling practices, and their perceived needs for training or assistance in providing mental health services to their parishioners. Following logically from previous research, it was hypothesized that attitudes about mental health and psychological service seeking will predict the nature of pastoral counseling as well as referral practices. In addition, information about type, frequency, and nature of counseling, referral practices, and perceived need for training or skills was gathered and analyzed. It is proposed that from

the results of this study, a training study can be developed that will help address the perceived needs of pastors in the area of mental health.

Taking the previous literature review into consideration, several hypotheses were developed:

1. Pastors who have more positive attitudes will demonstrate greater frequency and extent of counseling services provided to parishioners, and a greater number of topics on which they desire training.
2. Pastors who are more educated will have more positive attitudes toward mental health services.
3. Attitudes toward mental health services, church size, and pastor's education will serve as significant predictors for frequency of counseling.
4. Attitudes toward mental health services, church size, and pastor's education will serve as significant predictors for frequency of referral.
5. Additionally, the types of counseling that pastors do and the types of training they indicate needs for will be explored.

Method

Participants

An a priori factor analysis for a hierarchical multiple regression with three predictors and a medium effect size (partial $\eta^2 = 0.15$) indicated that a sample size of 107 was needed for appropriate power. Forty pastors completed the online survey. Because of incomplete responding, one participant's data was not used, resulting in a final N of 39. Pastors had a mean age of 49.15 ($SD=9.33$). There were 25 males and 14 females. Thirty-

two participants indicated that they were Black or African American, six said they were White or Caucasian, and two did not specify a race. This was a highly educated sample, with 95% of pastors responding having at least a bachelor's degree. Twenty-eight reported that they were full-time pastors.

In terms of church classifications, there was a wide distribution relative to size of church membership. Twenty five percent of pastors reported having fewer than 200 members, 20% reported having 200-350 members, 10% reported having 350-500 members, 15% reported having 500-1000 members, and 25% reported having over 1000 members. Nineteen (47.5%) pastors categorized their churches as urban, six (15%) said they had rural churches, and 12 (30%) said they had suburban churches. The overwhelming majority of pastors (82%) said that the average annual income at their churches was between \$25,000-\$40,000 (32.5%), \$40,000-\$60,000 (37.5%), or \$60,000-\$80,000 (12.5%). Twenty-seven pastors identified as Baptist or Missionary Baptist, six identified as United Methodist, three identified as African Methodist Episcopal, and one did not specify a denomination. Twenty-four pastors reported having some kind of pastoral care or counseling ministry at their churches.

Materials

Demographics. The first section of the survey asked demographic information such as gender, age, and level of education. In addition, pastors were asked about church demographics such as denomination, number of members/active members, type of church (urban/rural/ suburban), and other information.

Attitudes. Attitudes and perceptions about mental health were assessed with the Inventory of Attitudes toward Seeking Mental Health Services (IASMHS; Fischer, 1970; Mackenzie, Knox, Gekoski, & Macaulay, 2004; see Appendix A). This is a 24-item scale which is a revised version of Fischer's (1970) Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS). It has three subscales, which include: Psychological openness, Help-seeking propensity, and Indifference to stigma. It assesses attitudes towards mental healthcare use using a 5-point rating scale. Examples of items include: "There are certain problems which should not be discussed outside of one's immediate family" and "It is probably best not to know everything about oneself." Negatively worded items were reverse scored so that higher scores represented more positive attitudes toward mental health help seeking. This scale has been shown to have good internal consistency for the total score with a Cronbach's alpha of .87 (Mackenzie et al., 2004). In this study a Cronbach's alpha of .85 was found. This scale has been shown to be valid for adult populations showing convergent validity coefficients ranging from .21 through .38, and divergent validity coefficients ranging from -.37 through .08 (Mackenzie et al., 2004).

Counseling and Referral. Clergy responded to open-ended questions about the frequency, and type of congregational counseling they engage in. In addition, they will be asked about any training they may have in psychological issues, or training that they need.

Procedure

Pastors were recruited from various Virginia ministers' council organizations, and additional participants were recruited through the snowball method. This online survey was emailed out to pastors, through a representative of the organization. The emails sent out each contained the email recruitment script developed by the primary investigator. Pastors were informed that they could forward the survey to any pastors they thought might be interested in completing it.

Results

Attitudes toward Mental Health Services

This sample demonstrated relatively positive attitudes toward mental health services in general ($M = 75.95$, $SD = 8.57$). Pastors who reported counseling parishioners on a greater number of topics had higher scores on the IASMHS ($r(35) = .339$, $p < .05$), offering partial support for Hypothesis 1. Scores on the IASMHS were also positively associated with number of times per month counseling was performed ($r(38) = .388$, $p < .050$). The IASMHS was not significantly associated with percentage of pastoral time spent counseling members ($r(38) = .113$, $p = .49$) or the number of topics on which more training was desired ($r(37) = -.069$, $p = .68$).

Hypothesis 2, that pastors who are more educated will have more positive attitudes toward MHS, was not supported. Education was not significantly correlated with scores on the IASMHS ($r(38) = .088$, $p = .60$). This is most likely due to the restricted range of education exhibited by the pastors in this sample. Ninety-five percent of pastors surveyed had at least a bachelor's degree with about half of them holding doctoral-level degrees.

Counseling and Referral Practices

Twenty four (60%) pastors reported having some type of pastoral care or counseling ministry at their church, and 75% reported having seen a counselor or therapist at some point in their lives. Most pastors reported counseling parishioners a few times a month (40%) or a few times a week (22%). Eighty two percent of pastors indicated that they spent 30% or less of their pastoral time counseling parishioners. Table 1 lists percentages of pastors indicating they had counseled about each of several topics. Percentage of pastoral time spent counseling was significantly related to the number of topics addressed in counseling sessions ($r(35) = .510, p < .01$). Almost all pastors (88%) said that members came directly to them for pastoral care or emotional help. Nineteen pastors (47.5%) said they had sought out members who needed help, and about the same amount indicated that other members had alerted them about members who may need help. About 40% said that members had been sent to them by ministry leaders.

Table 1.

<i>Topics Addressed in Counseling Sessions</i>		
Topic	Percentage of Pastors who had discussed	Percentage of Pastors who want more training
Marital/ Family Problems	85%	72.5%
Substance Use/Abuse	52.5%	62.5%
Money Problems	47.5%	30%
Spiritual Problems	77.5%	27.5%
Sexual Problems	40%	45%
Job/work Problems	67.5%	27.5%
Educational Problems	43/5%	20%
Bereavement	77.5%	50%
Emotional Problems	62.5%	75%
Legal problems	35%	25%
Domestic/sexual abuse	42.5%	52.5%

Almost 90% of pastors reported ever having referred a member to an outside source for mental health services. Over half (61%) of pastors indicated that they refer a parishioner about once during a three month period, with another 25% saying they referred about twice within the same time frame. When asked to which types of agencies or professionals they referred to, most pastors (75%) said they had referred to a private therapist or counselor. Eighteen (45%) said they had referred to a community mental health center, and the same amount said they had referred to a social service agency.

Fifty-five percent said they had referred a parishioner to a church-based counseling center.

Surprisingly, 30 pastors (75%) indicated that they had received some type of training on how to counsel parishioners (also known as pastoral care). This could range from workshops, to coursework, to a degree in pastoral care or counseling. However, all but one of the pastors surveyed reported that they would benefit from some additional training. Table 1 lists percentages of pastors who indicated they would like training in various areas.

Predicting Frequency of Counseling and Referral

Hypothesis 3 predicted that attitudes toward MHS, church size, and pastor's education would be significant predictors for frequency of counseling done by pastors. This hypothesis was tested using a hierarchical multiple regression analysis. All of the assumptions for multiple regression were met. Attitudes toward MHS was entered in step 1, and church size and pastor's education were entered together in step 2. Results from the regression analysis indicated that attitudes toward MHS significantly predicted pastors' reported frequency of counseling $F(1, 36) = 5.50, p < .05; R^2 = .13$. However, the addition of pastor's education and church membership did not add any predictive value to the model, $F(1, 36) = 2.02, p = .13; R^2 = .15$. Attitudes remained a significant predictor when combined with the two additional variables. See Table 2 for regression statistics.

Table 2.

Predictors of Frequency of Pastoral Counseling

	Variable	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	SE	Beta		
Step 1	(Constant)	-.68	1.85		-.37	.72
	Attitudes toward MHS	.06	.02	.364	2.34	.025*
Step 2	(Constant)	-.78	2.11		-.37	.72
	Attitudes toward MHS	.05	.03	.33	2.05	.048*
	Level of Education	.02	.17	.017	.11	.92
	Church Membership	.11	.14	.14	.85	.40

Note: $\Delta R^2 = .02$ for Step 2, $p = .69$. * $p < .05$

Hypothesis 4 predicted that attitudes toward MHS, church size, and pastor's education will serve as significant predictors for referral. This hypothesis was tested using a hierarchical multiple regression analysis. All of the assumptions for multiple regression were met. Attitudes toward MHS was entered in step 1, and church size and pastor's education were entered together in step 2. In the first step, attitudes toward MHS were not found to significantly predict referral $F(1, 36) = .198$, $p = .66$, $R^2 = .005$. The addition of church size and pastor's education did not improve the predictive value for referral $F(3, 34) = .774$, $p = .52$, $R^2 = .06$. The hypothesis was not supported. See Table 3 for regression statistics.

Table 3.

Predictors of Pastoral Referral

	Variable	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	SE	Beta		
Step 1	(Constant)	2.10	.41		5.14	.000***
	Attitudes toward MHS	-.002	.005	-.07	-.45	.66
Step 2	(Constant)	1.92	.46		4.19	.000***
	Attitudes toward MHS	-.004	.005	-.13	-.76	.45
	Level of Education	.03	.04	.14	.85	.40
	Church Membership	.03	.03	.19	1.10	.28

Note: $\Delta R^2 = .06$ for Step 2, $p = .36$. *** $p < .001$

Open Ended Questions

Answers to open-ended questions were very minimal. In terms of how counseling sessions are initiated, several pastors mentioned that people outside their congregations and people in the community might refer people to them for help. In addition, one pastor mentioned that counseling sessions are often initiated during times of intercessory prayer at church, such as an “altar call” when all members engage in corporate prayer. When asked if there were additional topics they felt they could use training in, pastors suggested things like how to work with dysfunctional families, knowing when to refer members to outside resources, and knowing where referral resources are in the geographical area in which they are located. Clergy were also provided an additional space to make comments. Here are some excerpts from their comments:

“I always refer, refer, refer and follow up with the person.”

“Effective counseling requires more of an ongoing relationship between the caregiver and the care receiver, and is more in depth than the ministerial staff at our church provide. We provide a listening ear, some comfort, and prayer, but for anything more in depths, we encourage people to seek professional counseling.”

“Much formal and informal counseling is done in faith communities around the world due to the continuing stigma attached to mental health problems.”

“Many clergy persons do not possess such training but still hold great trust among laity. Seminaries should work diligently to close the gap between what is needed and what they currently provide.”

Discussion

The purpose of this study was to investigate pastors’ perceptions about and practice of mental health services within their churches. Data from various studies have indicated that churches serve in a mental health capacity for many African Americans (McMinn, et al., 1998; Milstein, et al., 2008; Young, et al., 2003). Using the model developed by Benes and colleagues, (2000), we can see that clergy often function in a direct service capacity caring for the mental and emotional needs of their parishioners. In addition, they are often the link between their parishioners and outside mental health professionals. As such, it is important to examine the attitudes that clergy have toward mental health both inside and outside of the church.

Based on the addition of attitudes to the Benes (2000) model, it was hypothesized that pastors who have more positive attitudes will demonstrate greater frequency and extent of counseling services provided to parishioners, and a greater number of topics on which they desire training. This hypothesis was partially supported by the fact that pastors who had more positive attitudes toward MHS reported counseling on a greater variety of

topics. Pastors who had more positive attitudes toward MHS also reported counseling parishioners more times per month. However, the IASMHS was not significantly associated the variety of topics on which training was desired. These results suggest that when pastors have more positive attitudes toward MHS, this directly translates into their work with their congregations.

These data underline the important role of pastors in the mental health of their parishioners. Their own personal opinions about mental health may greatly influence the kind of help their members receive. When seeking to address the stigma of mental health, especially in the African American church, pastors may prove to be an important point of intervention. Overall, these pastors seemed to be aware of and engaged in pastoral care within their churches. Over half of them said they had some type of counseling or pastoral care ministry, and most said they counseled parishioners at least a few times a month. This indicates that these pastors are consistently providing these services to their parishioners. Pastors also reported that these sessions were initiated in a variety of ways, with the most endorsement of members coming directly to them for help. Still, almost half said that they approached members who they thought might need help. This suggests that the church care relationship between the clergy person and the parishioner (see Figure 2) is in fact a two-way relationship. Pastors make an effort to deliver these types of help, even in cases where it may not be explicitly solicited by the parishioner.

Hypothesis 2, that pastors who were more educated would demonstrated more positive attitudes toward MHS services was not supported. This was in contrast with previous data which indicated that the level of education clergy members had attained

was directly associated with attitudes about mental health (Neighbors et al., 1998, Young et al., 2003). However, this sample was quite unusual in that 95% of the pastor's who participated had at least a bachelor's degree. Half of them have doctorates. This sample is not an accurate representation of African American pastors in that regard. This could also help explain their relatively high scores on the measure of attitudes toward mental health services. However, there is not enough variation in the level of education to develop a clear picture of the relationship, if any, between education and attitudes toward MHS in this sample.

Based on previous data it was hypothesized that attitudes toward MHS, church size, and pastor's education would predict frequency of both counseling and referral. Attitudes were found to predict counseling frequency, but not referral. Neither church size nor pastors' education was a predictor for frequency of counseling or for referral. Although there was some evidence that attitudes are related to referral and counseling practices, the relationship between the two variables in this sample is not enough to provide predictive utility. As predicted, attitudes had predictive validity for counseling frequency, such that when pastors had higher attitudes, they counseled more in their churches. However, the relationship between referral, attitudes, and education is still unclear. Here again, it is important to raise the point about the uniqueness of this sample. These pastors were mostly full-time, well-educated pastors who reported very positive attitudes toward MHS in general. For instance, while the full range of the IASMHS is from 0-96 points, the range for this sample was from 55-90 with a mean of around 76. Likewise, it has already been discussed how half of this sample had doctoral-level degrees. Having two variables

with such a restricted range could help explain why these variables were not significant predictors.

It is also equally as possible that these factors are not as relevant to referral and counseling practices as initially hypothesized. Because most of the previous studies looking at pastors' practices have used qualitative or correlational methods (e.g., Mattis et al., 2007; Neighbors et al., 1998, Young et al., 2003), there was no precedent for these variables being useful as predictors for pastoral counseling and referral. Perhaps rather than pastoral attitudes toward MHS and education, other variables such as relationship with parishioners and amount of pastoral time available for counseling are more important. Some of these issues were raised briefly in the adaptation of Benes' (2000) model (See Figure 2). At any rate, more research in this area is needed to ascertain which pastoral variables are most significantly related to counseling and referral in the church. Learning which factors are most important will help researchers develop mental health interventions aimed at African American faith communities.

Pastors reported counseling their members on a variety of topics (See Table 1), with the most popular being marital and family problems (85%), spiritual problems (77.5%), bereavement, (77.5%), and job or work problems (67.5%). Despite the variety of topics on which they currently counsel, all but one of the pastors surveyed reported that they could benefit from additional training in one or more areas. The topics selected by the greatest percentage of pastors were emotional problems (75%), marital and family problems (72.5%), substance use and abuse (62.5%), and domestic and sexual abuse (52.5%). While job/work problems and spiritual problems were two of the most

frequently reported topics about which counseling was done, they were two of the lowest in terms of perceived need for more training. This suggests that pastors feel more equipped to handle these two topics than some of the other areas of interest. For spiritual problems especially, it makes sense that pastors would feel most comfortable in what appears to be “their domain.” For job/work problems, pastors may see these issues as innocuous and not severe enough to require additional training or support. The most frequently endorsed problem on which more training was needed was emotional problems, a domain that has typically been addressed by mental health professionals. This is a clear area where pastors desire support, consultation, and/or training from the field of mental health. Interventions could focus on basic information such as signs of various disorders, ways symptoms can present, and basic helping skills for people who may have these kinds of problems.

The fact that such a large percentage of pastors endorsed needing additional training suggests that while pastors are operating in such a capacity that they offer counseling on a variety of topics. They may not feel fully equipped to offer appropriate counsel to their parishioners. It is also important to understand that pastoral care should not be conceptualized in the way that typical psychotherapy is. One pastor even indicated in additional comments that what is done in the church is “a listening ear, some comfort, and prayer, but for anything more in depth, we encourage people to seek professional counseling.” With this comment in mind, perhaps the most needed interventions are those which provide pastors with basic information about the issues their parishioners bring to them, and a clear process for deciding when to refer to a therapist or counselor. Because

members of faith communities have been using pastors as a resource for so long, there must be something effective about their counseling. However, they may not feel as confident about their ability to handle some of the more severe problems that are brought to them. Having an established procedure set up for determining when a parishioner's problems are too extreme for the pastor to handle on his or her own could provide an excellent service to the church community.

These data provide some preliminary information about the content of possible pastoral-level interventions addressing the mental health care needs of parishioners in faith communities. It is clear that there is a wide variety in the types of things people are choosing to address with their pastors. However, it is unknown whether pastors are receiving adequate training in these areas, or whether they know when it is necessary to refer their parishioners to an outside source. In addition, there is some evidence here for the fact that pastors who have more positive attitudes toward MHS services counsel about more topics and more often. A piece of Benes et al's (2000) model that is not directly addressed by this study has importance for a discussion in terms of what types of training pastors need. They argue that the relationship between pastors and clergy can take two different forms: consultation and referral (see Figure 1). However, in order to adequately meet the needs of members of faith communities, and African American faith communities in particular, the relationship has to be much more nuanced and diverse. As noted in Figure 2, an important piece of this picture is the "clergy-psychologist relationship." Pastors probably need to obtain a variety of services from psychologists, including consultation, supervision, and continual training in the latest developments of

mental health issues that are relevant to their church populations. In addition, because of the personal connection that pastors have with their parishioners, they need to feel that they can trust anyone to whom they are referring their members.

As noted earlier, one of the major limitations of this study is the nonrepresentative nature of this sample. It is likely that having a survey administered online greatly restricted the sample by eliminating pastors who could not be reached by email or were unable to access the survey online. In addition, these pastors were reached through formal ministerial or denominational organizations. Therefore, pastors who are not involved in some type of statewide or national religious organization were not recruited to participate. Variables such as having regular internet access and being involved in a formal ministerial organization could be tangentially related to openness about mental health and willingness to counsel. For instance, a person who is involved in a ministerial organization might be more likely to have a higher level of education, and could have access to more resources about mental health issues through said organization. Along another vein, pastors who do not have the internet as readily accessible are probably more likely to pastor in rural communities where there are limited mental health resources. In this case, pastors may actually engage in more counseling and less referral in order to meet the needs of parishioners, as suggested by Blank and colleagues (2002).

Future research in this area should focus on a more diverse sample of pastors to ascertain how these situational variables play a role in the counseling and referral that pastors engage in. In addition, process research that investigates that nature and quality of pastoral care being offered in churches would add to the current body of research. There

is little information about how effective church care is. For instance, there is little data on whether parishioners feel their problems are resolved after going to see a clergy person, or whether they feel like they need additional help. Data about how well clergy counseling works will help to better understand what is needed in terms of intervention.

This study adds to the current body of research on pastoral care in churches by assessing some of the topics that are most frequently discussed in counseling, and topics on which pastors desire more training. It highlights the importance of pastors' own attitudes about mental health services in their work with their parishioners. In addition, it suggests that pastors are in an important point of intervention for meeting the mental health needs of faith communities, especially African American faith communities. Results from this study indicate that even though pastors are actively engaged in counseling, they still desire more training. One future area to focus on may be a process by which pastors can determine at what point to refer their parishioners to professional mental health practitioners.

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Appendix A.

Online Survey

Please answer the following questions as honestly as possible. Your answers will be completely confidential. You may feel free to stop participation in this study at any time.

Personal Demographic Information

Gender _____ Age _____

Highest level of education (circle one)

Some high school

High school

Some college

College (Associate's or Bachelor's)

Was this work in religion? YES NO

Some graduate work

Was this work in religion? YES NO

Master's Degree (or JD)

Was this work in religion? YES NO

Some post-graduate work

Was this work in religion? YES NO

Doctorate (DMin, PhD)

Was this work in religion? YES NO

Are you a full time pastor? Yes No

If no, what is your other occupation? _____

Church Demographic Variables

What is the estimated membership of your church? (circle one)

Under 200 members

500-1000 members

200-350 members

350-500 members

Over 1000 members

How would you classify your church? (circle one)

Urban Rural Suburban Other (please list)_____

Are there full-time or part-time staff employed by your church? If so, how many? (not including you)

___ Full-time ___ Part-time

What is the average annual income (per household) of your parishioners? (circle one)

Under \$15,000	\$80,000-\$100,000
\$15,000-\$25,000	\$100,000-\$150,000
\$25,000-\$40,000	\$150,000-\$200,000
\$40,000-\$60,000	\$200,000-\$250,000
\$60,000-\$80,000	Over \$250,000

What is your church's denomination? (Please check one)

___ African Methodist Episcopal	___ Methodist
___ African Methodist Episcopal Zion	___ Nondenominational
___ Anglican	___ Missionary Baptist
___ Apostolic	___ Pentecostal
___ Baptist	___ Presbyterian
___ Church of God in Christ	___ Roman Catholic
___ Episcopal	___ United Church of Christ
___ Evangelical	___ United Holy Church
___ Free Will Baptist	___ United Methodist
___ Interdenominational	___ Other (please list)_____
___ Lutheran	

Does your church have a counseling or pastoral care ministry? Yes No

If yes, what are the responsibilities of this ministry?

IATSMHS

The term *professional* refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, and family physicians). The term *psychological problems* refers to reasons one might visit a professional. Similar terms include *mental health concerns*, *emotional problems*, *mental troubles*, and *personal difficulties*.

For each item, indicate whether you *disagree* (0), *somewhat disagree* (1), *are undecided* (2), *somewhat agree* (3), or *agree* (4) by circling the appropriate number.

1. There are certain problems which should not be discussed outside of one's immediate family.

0 1 2 3 4

2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.

0 1 2 3 4

3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.

0 1 2 3 4

4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.

0 1 2 3 4

5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional. .

0 1 2 3 4

6. Having been mentally ill carries with it a burden of shame.

0 1 2 3 4

7. It is probably best not to know *everything* about oneself.

0 1 2 3 4

8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.

0 1 2 3 4

9. People should work out their own problems; getting professional help should be a last resort.

0 1 2 3 4

10. If I were to experience psychological problems, I could get professional help if I wanted to.

0 1 2 3 4

11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.

0 1 2 3 4

12. Psychological problems, like many things, tend to work out by themselves.

0 1 2 3 4

13. It would be relatively easy for me to find the time to see a professional for psychological problems.

0 1 2 3 4

14. There are experiences in my life I would not discuss with anyone.

0 1 2 3 4

15. I would want to get professional help if I were worried or upset for a long period of time.

0 1 2 3 4

16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it.

0 1 2 3 4

17. Having been diagnosed with a mental disorder is a blot on a person's life.

0 1 2 3 4

18. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears *without* resorting to professional help.

0 1 2 3 4

19. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.

0 1 2 3 4

20. I would feel uneasy going to a professional because of what some people would think.

0 1 2 3 4

21. People with strong characters can get over psychological problems by themselves and would have little need for professional help.

0 1 2 3 4

22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.

0 1 2 3 4

23. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up."

0 1 2 3 4

24. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems.

0 1 2 3 4

The next section will ask about counseling behaviors within your own church. Remember that all of your answers will be kept totally confidential. You can stop participation in this study at any time. Please answer the following questions. You may feel free to add comments to your answers.

1. Have you ever been to see a counselor, therapist or psychologist? (circle one)

Yes

No

2. How often do you counsel your parishioners in a typical one month period? (check one)

- ☐ every day
- ☐ a few times a week
- ☐ a few times a month
- ☐ once a month
- ☐ a few times a year
- ☐ I never counsel my members

About what percentage of your time doing pastoral duties would you say is spent counseling members? (please check one)

- | | |
|---------------------------------|----------------------------------|
| <input type="checkbox"/> 0-10% | <input type="checkbox"/> 50-60% |
| <input type="checkbox"/> 10-20% | <input type="checkbox"/> 60-70% |
| <input type="checkbox"/> 20-30% | <input type="checkbox"/> 70-80% |
| <input type="checkbox"/> 30-40% | <input type="checkbox"/> 80-90% |
| <input type="checkbox"/> 40-50% | <input type="checkbox"/> 90-100% |

3. About what do you counsel your parishioners (please check all topics discussed)?

- | | |
|---|---|
| <input type="checkbox"/> Marriage/Family problems | <input type="checkbox"/> Bereavement |
| <input type="checkbox"/> Substance use/abuse | <input type="checkbox"/> Emotional Problems (ex.depression) |
| <input type="checkbox"/> Money problems | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Spiritual Problems | <input type="checkbox"/> Domestic/Sexual abuse |
| <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Other (please list)_____ |
| <input type="checkbox"/> Job/work problems | <input type="checkbox"/> Other (please list)_____ |
| <input type="checkbox"/> Educational problems | <input type="checkbox"/> Other (please list)_____ |

4. How are counseling sessions with members initiated? (check all that have occurred in the past)

- ☐ Members come to me
- ☐ I seek out members who seem to be in trouble

___ Other members tell me I should talk to members

___ Members speak to a ministry leader who will send them to me

___ Other (Please list)_____

Have you ever referred a member to another resource for counseling? (circle one)

YES

NO

If yes, how often do you refer parishioners to counseling services in a typical 3 month period?

___ once

___ twice

___ three times

___ four times

___ more than four times a month (list frequency)_____

5. List any sources to which you have ever referred a member:

___ community mental health center

___ social service agency (behavioral health authority, etc.)

___ private therapist/ counselor

___ church-based counseling center

6. Do you have any specialized training on how to counsel?

Yes_____ No_____

If yes, check any training have you received:

___ degree in counseling/pastoral care

___ coursework during a degree program

___ coursework outside of a degree program

___ attended a class/workshop outside of a degree program

Do you feel that you could benefit from additional counseling/psychological training?

Yes_____ No_____

7. If yes, in what areas do you feel that you could benefit from additional training in counseling/psychological training? (check all the apply)

___ Marriage/Family problems

___ Substance use/abuse

___ Money problems

___ Spiritual Problems

___ Sexual problems

___ Job/work problems

___ Educational problems

___ Bereavement

___ Emotional Problems (ex.depression)

___ Legal problems

___ Domestic/Sexual abuse

___ Other (please list)_____

___ Other (please list)_____

___ Other (please list)_____

10. Is there anything else you would like to add?

Vita

Jessica Janeé Young was born on April 11, 1986, in Richmond, Virginia, and is an American citizen. She graduated from Saint Gertrude High School in Richmond, Virginia in 2004. She received her Bachelor of Arts in Psychology and Spanish from Elon University, Elon, North Carolina in 2008 and subsequently came to Virginia Commonwealth University to pursue Counseling Psychology.